Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

Department of Health
Community & Family Health

and

Department of Social Health Services
Medical Assistance Administration

Prenatal Diagnosis Genetic Counseling
Billing Instructions

October 2000

About this publication

This publication supersedes all previous MAA Prenatal Genetic Counseling Billing Instructions and Numbered Memoranda 99-24 and 00-30.

Published by the Medical Assistance Administration
Washington State Department of Social and Health Services
October 2000

Received too many billing instructions?
Too few?
Address incorrect?

Please detach, fill out, and return the card located inside the back cover of this billing instruction. The information you provide will be used to update our records and provider information.

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Important Contacts

A provider may use MAA's toll-free lines for questions regarding its program. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs. (WAC 388-502-0020(2)).

Applying/inquiring about a provider #

Call:
Provider Enrollment Unit
(800) 562-6188 and
Select Option #1

or call one of the following numbers:

(360) 725-1026
(360) 725-1032
(360) 725-1033

Where do I send my claims?

Hard Copy Claims:
Division of Program Support
PO Box 9247
Olympia WA 98507-9247

Magnetic Tapes/Floppy Disks:
Division of Program Support
Claims Control
PO Box 45560
Olympia, WA 98504-5560

How do I obtain copies of billing instructions or numbered memoranda?

Check out our web site at:
http://maa.dshs.wa.gov

Or write/call:
Provider Relations Unit
PO Box 45562
Olympia WA 98504-5562
(800) 562-6188

Who do I contact if I have questions regarding…

Payments, denials, general questions regarding claims processing, or Healthy Options?

Call:
Provider Relations Unit (PRU)
(800) 562-6188

Private insurance or third party liability, other than Healthy Options?

Write/call:
Division of Client Support
Coordination of Benefits Section
PO Box 45565
Olympia, WA 98504-5565
(800) 562-6136

Electronic Billing?

Write/call:
Electronic Billing Unit
PO Box 45511
Olympia, WA 98504-5511
(360) 725-1267

Who do I contact for information regarding Regional Genetic Counseling clinics in my area?

Call:
Debra Lochner Doyle, MS, CGC
Department of Health
Genetic Counseling Section
(253) 395-6742

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Definitions

This section defines terms and acronyms used throughout these billing instructions.

Agency - A prenatal diagnosis genetic counseling service provider with at least one board certified or board eligible genetic counselor on staff who is supervised by a practicing licensed physician.

American Board of Genetic Counseling (ABGC) - A national organization that certifies genetic counselors. Prior to 1993, the certification of genetic counselors was conducted by the American Board of Medical Genetics (ABMG).

Authorization Number - A nine-digit number, assigned by MAA that identifies individual requests for services or equipment. The same authorization number is used throughout the history of the request, whether it is approved, pending, or denied.

Authorization Requirement - In order to obtain authorization for some services and equipment, you must provide proof of medical necessity. Each request must include a complete, detailed description of the diagnosis and/or any disabling conditions, justifying the need for the equipment or the level of service being requested.

Client – An applicant approved for, or recipient of, DSHS medical care programs.

Code of Federal Regulations (CFR) - A codification of the general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

Community Services Office(s) (CSO) - An office of the department [of Social and Health Services] which administers social and health services at the community level. (WAC 388-500-0005)

Core Provider Agreement - The basic contract that MAA holds with providers serving MAA clients. The provider agreement outlines and defines terms of participation in Medical Assistance.

Emergency Medical Condition – The sudden onset of a medical condition (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the patient's health in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part. (WAC 388-500-0005)

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Genetic Counselor - An individual who:

- Holds a post-baccalaureate degree; and
- Is qualified as a counselor and coordinator of services and resources in the care of persons with genetically caused and predisposed disorders.

Genetic Counselor, Board-certified /Board-eligible - A genetic counselor who has successfully passed the American Board of Medical Genetics (ABMG) general genetic examination as well as the subspecialty examination of genetic counseling (if prior to 1993) OR the American Board of Genetic Counseling examination. A ***board eligible genetic counselor*** has successfully completed an ABGC accredited training program and has been admitted to the next available ABGC certification examination. (held once every 3 years).

Health care providers - Persons licensed or certified by the state of Washington under Title 18 RCW to provide prenatal care or to practice medicine. (WAC 246-680-010)

Health maintenance organization (HMO) – See Managed Care.

Laboratory - A private or public person, agency, or organization performing prenatal tests for congenital and heritable disorders.

Managed Care - A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services. (WAC 388-538-050)

Maximum Allowable - The maximum dollar amount that a provider may be reimbursed by MAA for specific services, supplies, or equipment.

Medicaid - The state and federally funded aid program that covers the Categorically Needy (CNP) and Medically Needy (MNP) programs.

Medical Assistance Administration (MAA) - The administration within DSHS authorized by the secretary to administer the acute care portion of the Title XIX Medicaid, Title XXI Children's Health Insurance Program (CHIP), and the state-funded medical care programs, with the exception of certain non-medical services for persons with chronic disabilities.

Medical Assistance IDentification (MAID) card – MAID cards are the forms DSHS uses to identify clients of medical programs. MAID cards are good only for the dates printed on them. Clients will receive a MAID card in the mail each month they are eligible. These cards are also known as DSHS Medical ID cards or medical coupons.

Medically Necessary - A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. (WAC 388-500-0005)

Patient Identification Code (PIC) - An alphanumeric code that is assigned to each MAA client consisting of:

- First and middle initials (a dash (-) must be entered if the middle initial is not indicated).
- Six-digit birthdate, consisting of numerals only (MMDDYY).
- First five letters of the last name (and spaces if the name is fewer than five letters).
- Alpha or numeric character (tiebreaker).

Primary Care Case Management (PCCM) The health care management activities of a provider that contracts with the department to provide primary health care services and to arrange and coordinate other preventive, specialty, and ancillary health services (WAC 388-538-050)

Primary Care Provider (PCP) – A person licensed or certified under Title 18 RCW including, but not limited to, a physician and advanced registered nurse practitioner (ARNP), or a physician assistant who supervises, coordinates, and provides health services to a client or an enrollee, initiates referrals for specialist and ancillary care, and maintains the client's or enrollee's continuity of care. (WAC 388-538-050)

Program Support, Division of (DPS) – The division within MAA responsible for providing administrative services for the following:

- Claims Processing;
- Family Planning Services;
- Administrative Match Services to Schools and Health Departments;
- Managed Care Contracts;
- Provider Enrollment/Relations; and
- Regulatory Improvement.

Provider or Provider of Service - An institution, agency, or person:

- Who has a signed agreement [Core Provider Agreement] with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the department. (WAC 388-500-0005)

Remittance And Status Report (RA) - A report produced by MAA's claims processing system (known as the Medicaid Management Information System or MMIS) that provides detailed information concerning submitted claims and other financial transactions.

Revised Code of Washington (RCW) - Washington State laws.

Third Party - Any entity that is or may be liable to pay all or part of the medical cost of care of a program client. (WAC 388-500-0005)

Title XIX - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid. (WAC 388-500-0005

Usual & Customary Fee - The rate that may be billed to the department for a certain service or equipment. This rate may not exceed:

1) The usual and customary charge that you bill the general public for the same services; or
2) If the general public is not served, the rate normally offered to other contractors for the same services.

Washington Administrative Code (WAC) - Codified rules of the state of Washington.

About the Program

What is the purpose of the Prenatal Diagnosis Genetic Counseling program?

The Prenatal Diagnosis Genetic Counseling program was established to ensure that all Medical Assistance Administration (MAA) clients have access to high quality, comprehensive prenatal genetic health care services. Rapid advances in the field of genetics may outpace many obstetrical providers' abilities to stay current in standards of genetics practice and/or understand the complex ramifications oftentimes associated with genetic testing. In 1993, the Department of Health (DOH) and the Department of Social & Health Services (DSHS) established the Prenatal Diagnosis Genetic Counseling program to promote the use of genetic counselors. These health care professionals are nationally certified in the field of genetics and can ensure clients receive informed consent, particularly regarding reproductive issues. Funds in the DOH Division of Community & Family Health Genetic Services Section budget are used as the required state match for this reimbursement program for prenatal diagnosis genetic counseling services.

Referrals

Prenatal genetic counseling services are covered fee-for-service. No prior authorization is required. Clients in Medical Assistance fee-for-service and those enrolled in Healthy Options may self-refer or be referred by any provider. Clients in the Primary Care Case Management program must be referred by their Primary Care Case Manager. These services are available to all women/couples during their pregnancy and up to 90 days post-partum.

Client Eligibility

Who is eligible?

Pregnant clients presenting Medical Assistance IDentification (MAID) cards with the following identifiers are eligible for prenatal diagnosis genetic counseling during pregnancy and through the end of the month containing the 60th day after the pregnancy ends:

MAID Identifier	Medical Program
CNP	Categorically Needy Program
CNP-Children's Health	Children's Health
CNP-CHIP	Children's Health Insurance Program
CNP-Emergency Medical Only	Categorically Needy Program-Emergency Only
General Assistance-No Out of State Care	ADATSA, ADATSA Medical Only
LCP-MNP	Limited Casualty Program-Medically Needy Program

Who is <u>not</u> eligible?

Pregnant clients presenting Medical Assistance IDentification (MAID) cards with the following identifiers are not eligible for prenatal diagnosis genetic counseling*:

MAID Identifier	Medical Program
Detox Only	DETOX
MIP-EMER Hospital - No Out of State Care	Medically Indigent Program
Family Planning Only	Family Planning
GA-U No Out of State Care	General Assistance - Unemployable
QMB-Medicare Only	Qualified Medicare Beneficiary-Medicare Only

* These clients, if pregnant, may be eligible for other medical assistance programs that may cover prenatal diagnosis genetic counseling. Please refer pregnant clients to their local Community Services Office to be evaluated for a possible change in their medical assistance eligibility.

Clients enrolled in a Healthy Options managed care plan

No pre-authorization is required! Prenatal diagnosis genetic counseling services are not covered under MAA's Healthy Options managed care plans. However, clients enrolled in managed care may obtain prenatal diagnosis genetic counseling services through fee-for-service. (See *Referrals* on page 4.) If the client desires further prenatal procedures, such as amniocentesis, pre-authorization for such procedures is required by the client's Healthy Options managed care plan.

Clients with a plan identifier in the HMO column on their MAID cards are enrolled in one of MAA's Healthy Options managed care plans. Clients with a Primary Care Case Manager (PCCM) will have the PCCM identifier in the HMO column on their MAID cards.

Prenatal procedures beyond genetic counseling must be requested directly through the client's Primary Care Provider (PCP) or PCCM. For PCCM clients, the referral number is required in field 17A on the HCFA-1500 claim form. (See *General Billing* for further information.)

To prevent payment denials for services provided, please check the client's MAID card prior to scheduling services and at the time of service to make sure proper authorization for prenatal diagnostic procedures are obtained from the PCP or PCCM.

Coverage

What is covered?

MAA covers **one initial consultation** and **two follow-up consultations** per client, per pregnancy (11-month period) regardless of the provider or the place of service.

If a consultant initiates diagnostic or therapeutic services at the request of the provider, the service qualifies as a consultation. The purpose of a consultation is to provide a professional opinion and/or advice. The consultant must notify the client's healthcare provider in writing that he/she is initiating treatment at the provider's request and what course of action is being followed. A follow-up consultation involves the consultant's re-evaluation of a client for whom he/she previously rendered an opinion or advice.

Initial Consultations

MAA covers the following initial consultations:

- New Patient Office Visits: CPT codes 99201-99205

  ✓ *Use these codes when the client self-refers to the prenatal genetics counselor.*

- Office Consultations: CPT codes 99241 through 99245

  ✓ *Use these codes when another provider refers the client. The provider number of the referring provider must be included in the "ID Number of Referring Physician" box of the claim form in order to receive reimbursement.*

- Inpatient Consultations: CPT codes 99251 through 99255

  ✓ *Use these codes when another provider refers the client. The provider number of the referring provider must be included in the "ID Number of Referring Physician" box of the claim form in order to receive reimbursement.*

- Confirmatory Consultations: CPT codes 99271 through 99275

  ✓ *Use these codes when the consultant is providing an opinion and/or advise only (e.g. second or third opinion) and the consultant is aware of the confirmatory nature. Any services subsequent to the opinion are coded using the appropriate E&M code for an established patient.*

Follow-up Consultations

MAA covers the following follow-up consultations:

- Follow-Up Office Visits and Consultations: CPT codes 99211 through 99215

  ✓ *Follow-up visits or consultations in the consultant's office that are initiated by the physician consultant are reported using office visit codes for established patients.*

- Follow-Up Inpatient Consultations: CPT codes 99261 through 99263

  ✓ *Use these codes when another provider refers the client. The provider number of the referring provider must be included in the "ID Number of Referring Physician" box of the claim form in order to receive reimbursement.*

What is not covered?

MAA does not cover telephone or email consultations for prenatal diagnosis genetic counseling.

Provider Requirements

Who is eligible for reimbursement from MAA to provide prenatal diagnosis genetic counseling?

Only a prenatal diagnosis genetic counseling service provider (referred to as an "agency" in these billing instructions) is eligible for reimbursement from MAA to provide prenatal diagnosis genetic counseling. The agency must have at least one board-certified/board-eligible genetic counselor on staff who works with, and is supervised by, a practicing physician. The American Board of Genetic Counseling determines board certification/eligibility as of 1993.

What is my responsibility as a prenatal diagnosis genetic counseling provider?

- Agencies must provide prenatal diagnosis genetic counseling services according to policies and guidelines provided in these billing instructions and in the MAA Core Provider Agreement.

- MAA requires prenatal genetic counselors to:

  - ✓ Be able to elicit and interpret individual and family histories;
  - ✓ Know medical aspects of problems encountered in genetic service programs;
  - ✓ Know genetic and mathematic principles well enough to understand the limitations, significance, and interpretations of specialized laboratory and clinical procedures and to transmit and interpret genetic information to patients and families;
  - ✓ Be skilled in the interviewing and counseling techniques required to:

    - ➢ Elicit necessary information from the patient or family to reach appropriate conclusions about treatment and needs;
    - ➢ Anticipate areas of difficulty and conflict;
    - ➢ Help the families and individuals recognize and cope with their emotional and psychological needs;
    - ➢ Transmit pertinent information effectively;
    - ➢ Recognize situations that require referral;
    - ✓ Be knowledgeable enough about available health care resources to make appropriate referrals; and
    - ➢ Facilitate community referrals as indicated.

How do I become registered as a service provider?

1. Obtain a Core Provider Agreement from MAA or DOH Genetic Services Section.

2. Send:

   (a) The completed Core Provider Agreement
   (b) An ABMG/ABGC certification or a letter verifying genetic counselor's eligibility to sit for the upcoming examination; and
   (c) A photocopy of the supervising physician's license to:

   Debra Lochner Doyle, MS, CGC
   Department of Health
   Genetic Services Section
   Creekside 3 at Center Point
   20435 72nd Ave. S. Suite 200
   Kent, WA 98032
   (253) 395-6742
   email: debra.lochnerdoyle@doh.wa.gov

3. The Genetic Services Section staff will send a copy of approved Provider Agreement forms to MAA. This will serve as a written request to MAA for issuing an **MAA provider number**.

4. Agencies with existing MAA provider numbers for physician services will be issued a *separate* provider number **specific to prenatal diagnosis genetic counseling services** as provided by a board certified/board eligible genetic counselor.

5. After receiving the genetic counseling provider number, you may bill *retroactively* for services provided in accordance with MAA policies for clients (up to one year from the date of service). (See page 16 "What is the time limit for billing?")

Patient Authorization to Disclose Health Care Information

- Agencies must adhere to the Uniform Health Care Information Act (UHCIA), that prohibits agencies from releasing client information without the client's consent. **A valid authorization for disclosure must**:

  - ✓ Identify the nature of the information to be disclosed;
  - ✓ Identify the name, address, and institutional affiliation of the person to whom the information is to be disclosed;
  - ✓ Identify the physician or other health care provider who is to make the disclosure; and
  - ✓ Be in writing and be dated and signed by the patient.

- The expiration date of a valid disclosure authorization may not be more than 90 days in the future. If no date is specified, the authorization expires 90 days after it is signed. Furthermore, a patient may revoke a disclosure authorization at any time, unless it is required for payments to health care providers or other substantial action has been taken in reliance on the authorization.

- The UHCIA also contains provisions regarding patient representatives' access to records, retention and safeguarding patient records by providers, and remedies against providers who do not comply with the UHCIA.

Disclosing Patient Information <u>without</u> the Patient's Consent
(RCW 70.02.050)

- A health care provider may disclose health care information about a patient without the patient's authorization to the extent a recipient needs to know the information, if the disclosure is:

  - ✓ To a person who the provider reasonably believes is providing health care to the patient;

  - ✓ To any other person who requires health care information for health care education, or to provide planning, quality assurance, peer review, or administrative, legal, financial, or actuarial services to the health care provider; or for assisting the health care provider in the delivery of health care and the health care provider reasonably believes that the person:

    - ➢ Will not use or disclose the health care information for any other purpose; and
    - ➢ Will take appropriate steps to protect the health care information;

- ✓ To any other health care provider reasonably believed to have previously provided health care to the patient, to the extent necessary to provide health care to the patient, unless the patient has instructed the health care provider in writing not to make the disclosure;

- ✓ To any person if the health care provider reasonably believes that disclosure will avoid or minimize an imminent danger to the health or safety of the patient or any other individual, however there is no obligation under this chapter on the part of the provider to so disclose;

- ✓ Oral, and made to immediate family members of the patient, or any other individual with whom the patient is known to have a close personal relationship, if made in accordance with good medical or other professional practice, unless the patient has instructed the health care provider in writing not to make the disclosure;

- ✓ To a health care provider who is the successor in interest to the health care provider maintaining the health care information;

- ✓ For use in a research project that an institutional review board has determined:

    - ➢ Is of sufficient importance to outweigh the intrusion into the privacy of the patient that would result from the disclosure;
    - ➢ Is impracticable without the use or disclosure of the health care information in individually identifiable form;
    - ➢ Contains reasonable safeguards to protect the information from redisclosure;
    - ➢ Contains reasonable safeguards to protect against identifying, directly or indirectly, any patient in any report of the research project; and
    - ➢ Contains procedures to remove or destroy at the earliest opportunity, consistent with the purposes of the project, information that would enable the patient to be identified, unless an institutional review board authorizes retention of identifying information for purposes of another research project;

- ✓ To a person who obtains information for purposes of an audit, if that person agrees in writing to:

    - ➢ Remove or destroy, at the earliest opportunity consistent with the purpose of the audit, information that would enable the patient to be identified; and
    - ➢ Not to disclose the information further, except to accomplish the audit or report unlawful or improper conduct involving fraud in payment for health care by a health care provider or patient, or other unlawful conduct by the health care provider;

- ✓ To an official of a penal or other custodial institution in which the patient is detained;

- ✓ To provide directory information, unless the patient has instructed the health care provider not to make the disclosure;

- ✓ In the case of a hospital or health care provider to provide, in cases reported by fire, police, sheriff, or other public authority, name, residence, sex, age, occupation, condition, diagnosis, or extent and location of injuries as determined by a physician, and whether the patient was conscious when admitted.

- A health care provider [must] disclose health care information about a patient without the patient's authorization if the disclosure is:

  - ✓ To federal, state, or local public health authorities, to the extent the health care provider is required by law to report health care information; when needed to determine compliance with state or federal licensure, certification or registration rules or laws; or when needed to protect the public health;

  - ✓ To federal, state, or local law enforcement authorities to the extent the health care provider is required by law;

  - ✓ To county coroners and medical examiners for the investigations of deaths;

  - ✓ Pursuant to compulsory process in accordance with RCW 70.02.060.

Notifying Clients of Their Right to Make Their Own Health Care Decisions

All Medicare-Medicaid certified hospitals, nursing facilities, home health agencies, personal care service agencies, hospices, and managed health care organizations are federally mandated to give all adult clients written information about their rights, under state law, to make their own health care decisions.

Clients have the right to:

- Accept or refuse medical treatment;
- Make decisions concerning their own medical care; and
- Formulate an advance directive, such as a living will or durable power of attorney, for their health care.

Fee Schedule

Due to its licensing agreement with the American Medical Association, MAA publishes only the official, brief CPT™ procedure code descriptions. To view the full descriptions, refer to your current CPT book.

Procedure Code	Brief Description	7/1/04 Maximum Allowable Fee NFS	FS
Initial Office Visits			
99201	Office/outpatient visit, new	$24.25	$15.75
99202	Office/outpatient visit, new	43.25	31.25
99203	Office/outpatient visit, new	64.25	47.75
99204	Office/outpatient visit, new	90.75	70.50
99205	Office/outpatient visit, new	115.25	93.75
Initial Office Consultations			
99241	Office consultation	30.38	20.40
99242	Office consultation	55.31	41.94
99243	Office consultation	73.22	55.77
99244	Office consultation	103.38	82.52
99245	Office consultation	133.53	109.50
Initial Inpatient Consultations			
99251	Initial inpatient consult	21.54	21.54
99252	Initial inpatient consult	43.30	43.30
99253	Initial inpatient consult	58.94	58.94
99254	Initial inpatient consult	85.01	85.01
99255	Initial inpatient consult	116.98	116.98
Confirmatory Consultations			
99271	Confirmatory consultation	23.58	14.51
99272	Confirmatory consultation	39.22	27.43
99273	Confirmatory consultation	53.73	38.54
99274	Confirmatory consultation	72.54	55.99
99275	Confirmatory consultation	92.27	73.90

NFS = Non-facility Setting; FS = Facility Setting

Continued on next page…

Procedure Code	Brief Description	7/1/03 Maximum Allowable Fee NFS	FS
Follow-Up Office Visits or Consultations			
99211	Office/outpatient visit, est	$14.25	$6.00
99212	Office/outpatient visit, est	25.25	15.75
99213	Office/outpatient visit, est	35.25	23.75
99214	Office/outpatient visit, est	55.00	38.75
99215	Office/outpatient visit, est	79.75	62.25
Follow-Up Inpatient Consultations			
99261	Follow-up inpatient consult	13.60	13.60
99262	Follow-up inpatient consult	27.20	27.20
99263	Follow-up inpatient consult	40.13	40.13

NFS = Non-facility Setting; FS = Facility Setting

☞ **Note:** MAA covers **one initial office visit or consultation** and **two follow-up office visits or follow-up consultations** per client, per pregnancy regardless of the provider or the place of service.

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General Billing

Billing Procedures Specific to this Program

- Agencies must bill MAA on the HCFA-1500 claim form for services, using a separate prenatal diagnosis genetic counseling provider number assigned by MAA (See *Important Contacts*).

- Although providers have up to one year to bill to facilitate reconciliation of our account and reimbursement for unused funds, Regional Genetic Clinics with approved Core Provider Agreements ("agencies") are asked to submit billings within 120 days of the date of service.

What is the time limit for billing? (Refer to WAC 388-502-0150)

MAA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. MAA has two timeliness standards: 1) for initial claims; and 2) for resubmitted claims.

- **Initial Claims**

  ✓ MAA requires providers to submit an **initial claim** to MAA and obtain an ICN within 365 days from any of the following:

  - The date the provider furnishes the service to the eligible client;
  - The date a final fair hearing decision is entered that impacts the particular claim;
  - The date a court orders MAA to cover the services; or
  - The date DSHS certifies a client eligible under delayed[1] certification criteria.

☞ **Note:** If MAA has recouped a plan's premium, causing the provider to bill MAA, the time limit is 365 days from the date the plan recouped the payment from the provider.

[1] **Delayed Certification:** A person applies for a medical program prior to the month of service and a delay occurs in the processing of the application. Because of this delay, the eligibility determination date becomes later than the month of service. A delayed certification indicator will appear on the MAID card. The provider **MUST** refund any payment(s) for a covered service received from the client for the period he/she is determined to be medical assistance-eligible, and then bill MAA for those services.

- ✓ MAA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:

  - ➢ DSHS certification of a client for a retroactive[2] period; or
  - ➢ The provider proves to MAA's satisfaction that there are other extenuating circumstances.

- ✓ MAA requires providers to bill known third parties for services. See WAC 388-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties, in addition to MAA's billing limits.

- **Resubmitted Claims**

  - ✓ Providers may resubmit, modify, or adjust any timely initial claim, except prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

  ☞ **Note:** MAA does not accept any claim for resubmission, modification, or adjustment after the allotted time period listed above.

- The allotted time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument such as a bank check.

- The provider, or any agent of the provider, must not bill a client or a client's estate when:

  - ✓ The provider fails to meet these listed requirements; and
  - ✓ MAA does not pay the claim.

What fee should I bill MAA for eligible clients?

Bill MAA your usual and customary fee**.**

[2] **Retroactive Certification:** An applicant receives a service, then applies to MAA for medical assistance at a later date. Upon approval of the application, the person was found eligible for the medical service at the time he or she received the service. The provider **MAY** refund payment made by the client and then bill MAA for the service. If the client has not paid for the service and the service is within the client's scope of benefits, providers must bill MAA.

How do I bill for services provided to Primary Care Case Management (PCCM) clients?

For the client who has chosen to obtain care with a Primary Care Case Manager (PCCM), the identifier in the HMO column will be "PCCM." These clients must obtain their services through the PCCM. The PCCM is responsible for coordination of care just like the PCP is in a plan setting. Please refer to the client's MAID card for the PCCM.

When billing for services provided to PCCM clients:

- Enter the referring physician or PCCM name in field 17 on the HCFA-1500 claim form; and

- Enter the seven-digit, MAA-assigned identification number of the PCCM who referred the client for the service(s). If the client is enrolled with a PCCM and the PCCM referral number is not in field 17a when you bill MAA, the claim will be denied.

Newborns of Healthy Options clients who are connected with a PCCM are fee-for-service until a PCCM has been chosen. These services must be billed to MAA.

Note: If you treat a Healthy Options client who has chosen to obtain care with a PCCM and you are not the PCP, or the client was not referred to you by the PCCM/PCP, you may not receive payment. You will need to contact the PCCM/PCP to get a referral.

Third-Party Liability

You must bill the insurance carrier(s) indicated on the client's MAID card. An insurance carrier's time limit for claim submissions may be different from MAA's. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as MAA's, prior to any payment by MAA.

You must meet MAA's 365-day billing time limit even if you have not received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding MAA Remittance and Status Report for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by MAA, or if you have reason to believe that MAA may make an additional payment:

- Submit a completed claim form to MAA;
- Attach the insurance carrier's statement or EOB;
- If rebilling, also attach a copy of the MAA Remittance and Status Report showing the previous denial; or
- If you are rebilling electronically, list the claim number (ICN) of the previous denial in the Comments field of the Electronic Media Claim (EMC).

Third-party carrier codes are available on MAA's website at http://maa.dshs.wa.gov or by calling the Coordination of Benefits Section at 1-800-562-6136.

What records must be kept? [Refer to WAC 388-502-0020]

Enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

  - ✓ Patient's name and date of birth;
  - ✓ Dates of service(s);
  - ✓ Name and title of person performing the service, if other than the billing practitioner;
  - ✓ Chief complaint or reason for each visit;
  - ✓ Pertinent medical history;
  - ✓ Pertinent findings on examination;
  - ✓ Medications, equipment, and/or supplies prescribed or provided;
  - ✓ Description of treatment (when applicable);
  - ✓ Recommendations for additional treatments, procedures, or consultations;
  - ✓ X-rays, tests, and results;
  - ✓ Dental photographs/teeth models;
  - ✓ Plan of treatment and/or care, and outcome; and
  - ✓ Specific claims and payments received for services.

- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.

- **Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, for at least six years from the date of service or more if required by federal or state law or regulation.**

How to Complete the HCFA-1500 Claim Form

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

General Instructions

- Please use an original, red and white HCFA-1500 (U2) (12-90) claim form.
- Enter only one (1) procedure code per detail line (field 24A-24K). If you need to bill more than six (6) lines per claim, please complete an additional HCFA-1500 claim form.
- You must enter all information within the space allowed.
- Use upper case (capital letters) for all alpha characters.
- Do not write, print, or staple any attachments in the bar area at the top of the form.

Field Description/Instructions for Completion

1a. **Insured's I.D. NO.**: Required. Enter the MAA Patient (client) Identification Code (PIC) - an alphanumeric code assigned to each MAA client. This information is obtained from the client's current monthly Medical Assistance IDentification (MAID) card consisting of the client's:

a) First and middle initials (a dash [-] *must* be used if the middle initial is not available)
b) Six-digit birthdate, consisting of *numerals only* (MMDDYY)
c) First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
d) An alpha or numeric character (tiebreaker)

For example:

1. Mary C. Johnson's PIC looks like this: MC010667JOHNSB.
2. John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B.

2. **Patient's Name**: Required. Enter the last name, first name, and middle initial of the MAA client (the receiver of the services for which you are billing).

3. **Patient's Birthdate**: Required. Enter the birthdate and sex of the MAA client.

4. **Insured's Name (Last Name, First Name, Middle Initial)**: When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same – then the word *Same* may be entered.

5 **Patient's Address**: Required. Enter the address of the MAA client who has received the services you are billing for (the person whose name is in *field 2*.)

9. **Other Insured's Name**: When applicable, show the last name, first name, and middle initial of the insured if it is *different from* the name shown in *field 4*. Otherwise, enter the word *Same*.

9a. Enter the other insured's policy or group number *and* his/her Social Security Number.

9b. Enter the other insured's date of birth.

9c. Enter the other insured's employer's name or school name.

9d. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, private supplementary insurance).

Please note: DSHS, Welfare, Provider Services, Healthy Kids, HO or Healthy Options First Steps, and Medicare, etc., are inappropriate entries for this field.

10. **Is Patient's Condition Related To**: Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**: When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage MAA pays as payer of last resort.

11a. **Insured's Date Of Birth**: When applicable, enter the insured's birthdate, if different from *field 3*.

11b. **Employer's Name or School Name**: When applicable, enter the insured's employer's name or school name.

11c. **Insurance Plan Name or Program Name**: When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11d. **Is There Another Health Benefit Plan?:** Indicate *yes* or *no*. If yes, you should have completed *fields 9a. - d*.

17. **Name of Referring Physician or Other Source**: When applicable, enter the referring physician or Primary Care Case Manager (PCCM) name. This field *must* be completed for consultations, or for referred laboratory or radiology services (or any other services indicated in your billing instructions as requiring a referral source).

17a. **I.D. Number Of Referring Physician**: When applicable, 1) enter the seven-digit, MAA-assigned identification number of the provider who *referred or ordered* the medical service; OR 2) when the PCCM referred the service, enter his/her seven-digit identification number here. *If the provider does not have an MAA provider ID number, be certain field 17 is completed.*

21. **Diagnosis or Nature of Illness or Injury**: When applicable, enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4.

22. **Medicaid Resubmission**: When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.)

23. **Prior Authorization Number**: When applicable. If the service or equipment you are billing for requires authorization, enter the nine-digit number assigned to you. Only one authorization number is allowed per claim.

24A. **Date(s) of Service**: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., October 4, 2000 = 100400).

24B. **Place of Service**: Required. These are the only appropriate code(s) for Washington State Medical Assistance:

Code	To Be Used For
1	Inpatient hospital
2	Outpatient hospital
3	Office

24C. **Type of Service**: Required. Enter a **3** for all services billed.

24D. **Procedures, Services or Supplies CPT/HCPCS**: Required. Enter the appropriate procedure code for the services being billed. **Modifier**: When appropriate enter a modifier.

24E. **Diagnosis Code**: Required. Enter the ICD-9-CM diagnosis code related to the procedure or service being billed (for each item listed in 24D). A diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM, or relate each line item to *field 21* by entering a 1, 2, 3, or 4.

24F. **$ Charges**: Required. Enter your usual and customary charge for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not include sales tax. Sales tax is automatically calculated by the system and included in your remittance amount.

24G. **Days or Units**: Required. Enter the total number of days or units for each line. These figures must be whole units.

25. **Federal Tax I.D. Number: Leave this field blank.**

26. **Your Patient's Account No.**: This is any nine-digit alphanumeric entry ***that you may use as your internal reference number***. *You* create this number. Once you have submitted this account number to MAA, it will appear on the Remittance and Status Report.

28. **Total Charge**: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid**: If you receive an insurance payment or client paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify the source in *field 10d*. Do not use dollar signs or decimals in this field or put Medicare payment here.

30. **Balance Due**: Required. Enter balance due. Enter total charges minus any amount(s) in *field 29*. Do not use dollar signs or decimals in this field.

33. **Physician's, Supplier's Billing Name, Address, Zip Code and Phone #**: Required. Put the *name and address* on all claim forms.

Group:

This is the seven-digit number assigned by MAA to a provider group that identifies the entity (e.g., genetics clinic, lab, hospital emergency room, etc.). When a valid group number is entered in this field, payment will be made under this number.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

SAMPLE

Prenatal Diagnosis Genetic Counseling

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☒ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): PJ090824LONG B

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): LONG, PETE J.

3. PATIENT'S BIRTH DATE: MM 09 DD 08 YY 24 SEX: M ☒ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 62 SOUTH STREET

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN STATE: WA

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐

CITY: STATE:

ZIP CODE: 98000 TELEPHONE (Include Area Code): ( )

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☒

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☒ PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	04	15	00	04	15	00	3	3	9063M		317	10000	1				
2																	
3																	
4																	
5																	
6																	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.: 123456

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. $ TOTAL CHARGE: 10000

29. $ AMOUNT PAID:

30. $ BALANCE DUE: 10000

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

GENETICS OF WASHINGTON 360-222-1111
123 8TH STREET
ANYTOWN WA 98500

PIN# GRP# 7044444

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500